MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

February 2009

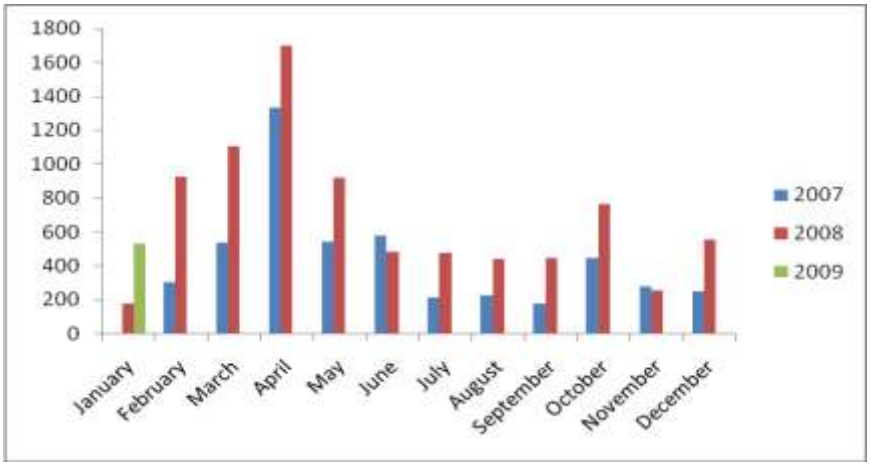
CENTER FOR INFORMATION SYSTEMS AND ANALYSIS

Maryland Trauma Physician Services Fund

Uncompensated Care Processing

CoreSource, Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $558,631 in December and $532,610 in January. The monthly payments for uncompensated care over the past 25 months are shown below in Figure 1.

Figure 1 – Uncompensated Care Payments 2007-2009



Trauma Equipment Grants

The Commission received Trauma Equipment Grant applications from each of the Level II and Level III trauma centers for the FY 2009-2010 grant cycle.

On-Call Applications

The Commission received applications for on-call reimbursement from each of the Level II and Level III trauma centers for the July 1 through December 31, 2008 semi-annual period.

Reconciliation Reports

Maryland trauma physicians who have received uncompensated care payments from the Fund are required to file an annual reconciliation report no later than January 31st of each calendar year.

COMAR 10.25.10 – Maryland Trauma Physician Services Fund
Staff's proposed changes to COMAR 10.25.10 conform the Commission's regulations to the statutory changes that became effective in July 2008. The proposed revisions were written in consultation with staff from the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the Health Services Cost Review Commission (HSCRC), and the members of TraumaNet. The proposed changes will be considered by the Commission at this month's meeting.

Cost and Quality Analysis

Health Insurance Coverage
The health insurance coverage report, *Health Insurance Coverage in Maryland through 2007*, will be presented at the February 2009 Commission meeting. The State's most recent nonelderly uninsured and employment-based coverage rates for 2006–2007 are not significantly different from those rates in 2004–2005. In 2006–2007, about 760,000 nonelderly state residents lacked health insurance, amounting to 15.4 percent of Maryland's nonelderly population. However, the latest uninsured rate is significantly higher than the state's rate in 2002-2003, 14.4 percent. As in prior periods, Maryland's 2006–2007 uninsured rate is below the comparable national average, 17.5 percent, due to a higher rate of employment-based coverage in the state than in the nation as a whole.

The report contains information on the characteristics of Maryland's uninsured nonelderly residents, as well as the coverage rates for many subsets of the population, including children, young adults, workers, and racial and ethnic minorities. As in the larger population, the coverage rates for most subgroups did not change from 2004–2005 to 2006–2007. The uninsured rates among children, 10 percent, and nonelderly adults, 17 percent, were stable, reflecting no significant changes in their private or public coverage rates. The demographic composition of the state's nonelderly uninsured shifted slightly with respect to income (relatively fewer poor residents), race/ethnicity (relatively more Hispanics), and employment (relatively fewer from families lacking an employed adult).

Age, educational attainment, and family income are closely associated with being uninsured. About 30 percent of young adults (ages 19-29) lack insurance. Nearly half of all individuals in families where the adults had not attained a high school diploma are uninsured. About 22 percent of children and 43 percent of adults in low-income families are uninsured. Persons in families with low incomes—at or below 200 percent of the poverty level—are 19 percent of Maryland's nonelderly, but comprise 44 percent of the state's uninsured. About half of Maryland's Hispanic residents lack coverage, so although they are just eight percent of the state's nonelderly, they comprise 24 percent of the uninsured, up from 19 percent in 2004–2005 when they were also eight percent of the nonelderly. Nine of 10 uninsured persons in Maryland live in family units with at least one working adult, and 60 percent are working adults. Adults working in private firms with fewer than 100 workers are 37 percent of adult workers, but account for 62 percent of uninsured adult workers.

Racial Differences in Hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs)
MHCC staff has been investigating ways to provide race-specific hospitalization rates for ACSCs by jurisdiction (or groups of counties) on an on-going basis. These rates would be based on the demographic composition of each jurisdiction's adult population and hospital discharges for all adults. The discharge data will need to include all discharges for Maryland adults, regardless of the hospital's location. MHCC already has data on discharges from Maryland and District of Columbia hospitals, but will need to obtain discharges for Maryland adults from Delaware, Pennsylvania, and West Virginia hospitals for the rates to be accurate, especially for those jurisdictions that border these states. Discussions with DHMH staff have indicated a potential source for these out-of-state discharges. Additionally, the Agency for Healthcare

Research and Quality (AHRQ) has recently initiated a program to provide states with the software and training needed to host AHRQ tools—including the ACSC rates in tables and/or maps—on their own websites. MHCC plans are still in the development stages regarding utilization of the AHRQ software, but it is likely that the initial version of the ACSC tools will be targeted at county health department staff, who will be recruited to test the website and provide comments.

State Health Care Expenditures Report
Data problems have delayed progress on the report. The MHCC has been unable to obtain Medicare data ordered in July 2008 from the Centers for Medicare and Medicaid Systems (CMS) due to a change in the vendors CMS uses to process Medicare claims data. Additionally, anomalies in the information contained in the insurance filings of several large private insurers have necessitated supplementary investigations into the enrollments and expenditures for these companies. Consequently, the presentation of the report has been delayed to the March Commission meeting.

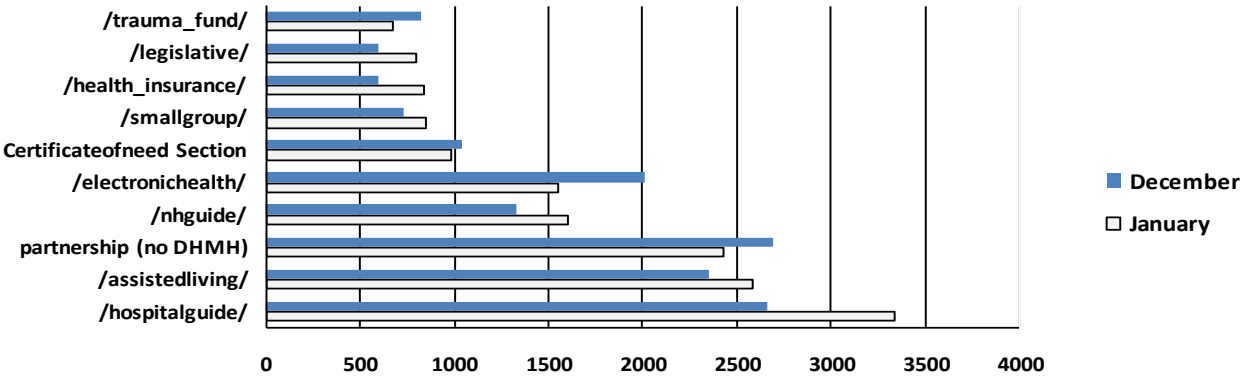
Data and Software Development

Internet Activities
Figure 2 presents results on web utilization for the Commission's ten most frequently visited sites for December 2008 and January 2009. The total number of visits in December dropped about 7 percent from those in November, and then increased in January about 7 percent, representing about 23,000 visits.

The Hospital Performance Guide, shown as "Hospital Guide" below, was the site with the highest utilization in both December and January. It continues to be one of the most heavily visited sites. The Guides (Hospital, Assisted Living, and Nursing Home, shown as "NH Guide" below) all had significant traffic during both months. In December, the number of visits stayed about the same as November, while in January the traffic increased by about 18.5%. In December, the Hospital Guide and the Health Insurance Partnership site traffic dropped about 10%. The largest decrease in traffic was on the Electronic Health Initiatives site in December, from 3,000 visits in November to 2,000 in December. In January, the Hospital Guide usage increased the most for any of the MHCC sites, 12%. The other two sites declined again. The Health Insurance Partnership site usage dropped by 11% and the Electronic Health Initiatives site usage dropped 23% in January.

Several web analytics continued to trend favorably during the past three months. The average number of pages viewed and the average time on the site were steady. About 30% of all visitors originate from a Maryland-based ISP. Those visitors tend to view more pages and spend longer time on the site.

Figure 2: Visits to the MHCC Web Sites
Top 10 MHCC Sites during December 2008 & January 2009



Web Development

Staff continued to make progress on web applications for the MHCC and the health occupation boards. Table 1, below, presents the status of development for health occupation boards. The limited staff available for development of the current workload has forced MHCC to scale back support to the Boards in the last several months.

The development staff is prioritizing MHCC's web development for new sites that provide new or additional information on quality and costs to stakeholders. The second priority will be improving existing web-based surveys that are administered to various providers, including long-term care, home health, and insurance carriers. The MHCC Assessment and OfficeTrak systems will also be given a lower priority.

Table 1

Board	Anticipated Start Development/Renewal
Acupuncture	Underway/in Production
AHRQ QI Installation	February 2009
MHCC User Fee Assessment	Underway
Audiology/Hearing Aid Dispensers/Speech and Language Pathologists	Underway/In Production Mode
Chiropractors	Underway/ In Production Mode
Dental Examiners	Underway/In Production Mode
Dietetic Practice	Underway/In Production Mode
MHCC Health Insurance Partnership	Underway/In Production Mode
Morticians	Underway/In Production Mode
Nuclear Medicine Technicians	Development
MHCC Nursing Home Survey Design	**Planning**
Occupational Therapy Practice	Underway/In Production Mode
MHCC OfficeTrak	Underway
Pharmacy	Underway/In Production Mode
Physical Therapy Examiners	Underway/In Production Mode
Physicians	Underway/In Production Mode
Physicians – Licensed Respiratory Care Practitioners	Development
Physicians – Physicians Assistants	Development
Physicians – Radiation Technicians	**Planning**
Podiatric Medical Examination	Underway/In Production Mode
Social Work Examiners	Underway/In Production Mode

CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES

HMO Quality and Performance

2008 Plan Performance Evaluation: HEDIS Audit and CAHPS Survey

Report Development—State Employee Guide
Health Plan Quality & Performance Division staff has begun work on the third, and final, report in the series, *Measuring the Quality of Maryland Commercial Managed Care Plans: 2009/2010 State Employee Guide.* The report will be available on MHCC's website. State employees will be directed to view a copy of the report online through notices in DBM's employee benefit booklet sent during the open enrollment period. DBM will distribute employee benefit booklets in mid-April.

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)
At the December 2008 public meeting, the Commission adopted proposed permanent regulations to implement the following changes to the CSHBP: requiring coverage for dependents up to age 25, and requiring coverage for the surgical treatment of morbid obesity. The regulations were posted in the Maryland Register on January 30, 2009 for the required comment period, which ends on March 3rd. At the March meeting, Commission staff will present the final regulations for Commission approval. Upon approval, these coverage changes will apply to policies beginning July 1, 2009.

Health Insurance Partnership
The premium subsidy program known as "The Partnership" is available to certain small employers with 2 to 9 full time employees as long as they meet the requirements outlined in the law and meet certain salary, wage and other eligibility requirements established by the Commission through regulation. Coverage under the Partnership began on October 1, 2008. As of February 9th, enrollment in the Partnership was as follows: 122 employer groups; 386 employees; 629 covered lives. The average subsidy per enrolled employee is $1,850; the average age of all enrolled employees is 38; the group average wage is $28,000; the average number of employees per policy is 4.3; and the total subsidy amount issued is $715, 000.

Commission staff created and continually maintains the Partnership website (http://mhcc.maryland.gov/partnership) to inform all interested parties, including, carriers, producers, employers, employees, various business associations, etc., about this program.

Mandated Health Insurance Services
As required under Insurance Article § 15-1501, Annotated Code of Maryland, the Commission is required to submit an annual report to the General Assembly on: (1) any proposed mandated health insurance service that failed during the preceding legislative session; and (2) any request for analysis on a proposed mandated benefit that was submitted by a Legislator to the Commission by July 1st of that year. Each evaluation must include an assessment on the medical, financial, and social impact of the proposed mandate. The 2008 report, prepared by Mercer, the Commission's consulting actuary, included an evaluation on the following five (5) proposed mandates: coverage for prosthetic devices; extending the current mandate on coverage for in vitro fertilization; coverage for the shingles (herpes zoster) vaccine;

coverage for autism spectrum disorder; and coverage for a 48-hour inpatient stay following a mastectomy. At the December 2008 meeting, the Commission approved the report, which was submitted to the Governor and the General Assembly prior to its due date of December 31, 2008.

Long Term Care Policy and Planning

Home Health Study
A report, entitled *An Alternative to the Regulation of Home Health Agencies in Maryland* was submitted, with a transmittal letter, as well as a cover letter from the Commission, to the House Health and Government Operations Committee prior to the December 31st due date. This report is posted on the Commission's website. Dr. Cowdry presented this report to the Health Facilities and Occupations Subcommittee of the Health and Government Operations Committee on January 21, 2009.

Hospice Data
The Commission, working with OCS as its contractor, conducts the annual Maryland Hospice Survey. Work is underway to revise the survey for the FY 2008 data collection. Commission staff met with hospice providers on December 9, 2008 to review proposed changes to the survey. These changes are now being programmed for online survey completion. It is anticipated that the FY 2008 Maryland Hospice Survey will be ready for online data submission by the middle of February.
In addition, OCS has completed work on a Trend Analysis of hospice data for the time period of 2004 through 2007. This shows the differences in variables from year to year and indicates where differences are statistically significant. This Trend Analysis is accompanied by a Statistical Testing Guide that helps the reader to understand what significance tests are being applied and what caveats must be used in interpreting the data. This Trend Analysis will be updated as additional years of data become available. This Trend Analysis will also be posted on the Commission's website.

Chronic Hospital Occupancy Report
As required under COMAR 10.24.08, a notice was published in the January 2, 2009 *Maryland Register* to update Chronic Hospital Occupancy for FY 2007. This report is required to be updated annually. It reports data on occupancy for both private and state-operated chronic hospitals. The private chronic hospitals include James Lawrence Kernan Hospital; Johns Hopkins Bayview Medical Center; Levindale Hebrew Geriatric Center and Hospital; University Specialty Hospital; and Gladys Spellman Specialty Hospital and Nursing Center. The state-operated chronic hospitals include Western Maryland Center and Deer's Head Hospital Center.

Home Health Data
The data collection for Phase 1 Agencies (agencies with fiscal year end dates of March 31, May 31, and June 30, 2008) have been completed. Phase 2 Agencies- Agencies with fiscal year end dates of September 30, and December 31, 2008 data collection will begin on March 1, 2009. The due date for Phase 2 agencies is May 29, 2009.

Long Term Care Survey
Staff is in the final stages of the post data collection – cleaning of the data. It is anticipated that 2007 public use data sets will be available to the public within the next month.

Long Term Care Quality Initiative

Nursing Home Family Survey
Survey data collection ended in January. This is the first year trend data will be reported; therefore, the report template, analysis and explanation of results require modification to adequately explain the 2008 survey results. Facility specific reports will be mailed to nursing homes by the end of February. A briefing will be scheduled for the March or April Commission meeting.

Long Term Care Web Site Enhancement
Development of the enhanced long term and community based services component of the website continues. Recent web site feedback from consumer advocates has identified several site changes to the nursing home guide that will enhance clarity and ease of navigation.

Maryland Nursing Home Guide Update
Meetings between OHCQ and MHCC continue with the goal to add display of written annual and complaint survey reports to the Guide to be implemented later in the calendar year.

In preparation for the annual update of facility characteristics staff has spent considerable time reconciling nursing home data submitted for calendar year 2007 via the LTC survey. Verification of changes in nursing home name, bed capacity, and bed configuration that occurred after December 31, 2007 are also in being completed so the data posted is the most current available.

Other
Of note is the release by CMS in December 2008 of the Five Star Rating System for nursing homes as a part of CMS *Nursing Home Compare.* Each nursing home receives a star rating for three types of performance measures: health inspections, staffing, quality measures, and an overall star rating of one to five stars based on performance. The web address to view the site is http://www.medicare.gov/nhCompare/.

Staff attended a policy seminar sponsored by Academy Health and The Commonwealth Fund on the topic of Disparities in Long Term Care.

CENTER FOR HOSPITAL SERVICES

Hospital Services Policy and Planning

Certificate of Need (CON): December 1, 2008 through January 31, 2009

CONs Issued
Shady Grove Nursing & Rehabilitation Center (Montgomery County)
Docket No. 08-15-2281
Relocation of 4 comprehensive care beds from Springbrook Nursing Center to Shady Grove.
Estimated Cost: $1,373,093

Kennedy Krieger Hospital (Baltimore City)
Docket No. 08-24-2282
Relocation of 2 inpatient special hospital pediatric programs (Neurobehavioral Unit and the Pediatric Feeding Disorder Unit) from the Hospital building located at 707 North Broadway to another Hospital building located at 1750 E. Fairmount Avenue.
Estimated Cost: $5,500,000.

Approved CON's Relinquished by Applicant

Fairland Nursing & Rehabilitation Center (Montgomery County)
Docket No. 06-15-2178
Renovations to the existing nursing center, construction of a new building, transfer of 55 CCF beds from Springbrook Nursing & Rehabilitation Center and the licensing of 10 waiver beds taking the facility from 92 to 157 CCF beds
Relinquished: 12/29/08

Fairland Nursing & Rehabilitation Center (Montgomery County)
Docket No. 07-15-2197
Relocation of 20 temporarily delicensed CCF beds from Holy Cross Hospital to the previously approved project (06-15-2178)
Relinquished: 12/29/08

Proposed CON's Withdrawn by Applicant

Carroll Hospital Center (Carroll County)
Docket No. 07-06-2198
Construction of a 2-story tower (East Tower) and an increase of 36 med/surg beds at the hospital
Withdrawn: 12/29/08

CON Letters of Intent

Baltimore Washington Medical Center (Anne Arundel County)
Addition of 4 mixed-use operating rooms to the current surgical suite at the hospital

Harford Memorial Hospital (Harford County)
Addition of 16 m/s/g/a beds through renovations and equipping of existing hospital space

Fairland Adventist Nursing & Rehabilitation Center (Montgomery County)
Construction of a replacement facility from the current site of 2101 Fairland Road, Silver Spring to 12110 Plum Orchard Road, Silver Spring and an increase in beds from 92 to 169 beds by relocating, 10 waiver beds, 20 CCF beds from Holy Cross TCC (previously approved CON 07-15-2197,) and transferring 47 CCF beds from Springbrook N & R Center.

Johns Hopkins Bayview Medical Center (Baltimore City)
Construction of 4 new mixed-use operating rooms to be located in the general operating suite at the hospital

Springwell Skilled Care & Rehabilitation Center (Baltimore City)
Construct a new comprehensive care facility by relocation of 75 temporarily delicensed CCF beds from The Wesley to a new location at 2211 Rogers Avenue, Baltimore

CON Applications Filed

Johns Hopkins Bayview Medical Center (Baltimore City)
Matter No. 08-24-2289
Construction of 4 new mixed-use operating rooms to be located in the general operating suite at the hospital. Cost $24,465,597
December 15, 2008

Pre-Application Conference

Community Care Nursing Services
Provide specialty home health services to pediatric patients in the State of Maryland
December 3, 2008

Determination of Coverage

- **Acquisitions**

Ruxton Health of Denton (Caroline County)
Lease of the facility by HC REIT to Envoy Health Care, LLC

Ruxton Health of Pikesville (Baltimore County)
Lease of the facility by HC REIT to Envoy Health Care, LLC

- **Capital Threshold**

Forest Haven Nursing Home (Baltimore County)
Construction of a 2-story masonry addition and conversion of day room to 6 new private patient rooms.
Cost: $824,389

- **Delicensure of Bed Capacity or a Health Care Facility**

Liberty Heights Nursing & Rehabilitation Center (Baltimore City)
Temporary delicensure of 8 CCF beds

Chesapeake Shores (St. Mary's County)
Temporary delicensure of 5 CCF beds

Signature HealthCARE at Mallard Bay (Dorchester County)
Temporary delicensure of 20 CCF beds

Homewood Center (Baltimore City)
Temporary delicensure of 4 CCF beds

Cromwell Center (Baltimore County)
Temporary delicensure of 10 CCF beds

Perring Parkway Center (Baltimore County)
Temporary delicensure of 9 CCF beds

Caton Manor (Baltimore City)
Temporary delicensure of 12 CCF beds

- **Relicensure of Bed Capacity or a Health Care Facility**

Harford Gardens Harborside Healthcare (Harford County)
Relicensure of 20 temporarily delicensed CCF beds

- **Relinquishment of Bed Capacity**

Renaissance Gardens at Charlestown (Baltimore County)
Relinquishment of 10 CCF beds

College View Center (Frederick County)
Relinquishment of 18 CCF beds

- **Other**

Good Samaritan Nursing Center (Baltimore City)
Revision of Medicaid Memorandum of Understanding

- **Ambulatory Surgery Centers**

Summit Ambulatory Surgical Center, LLC (Harford County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 251 Lewis Lane, Suite 203, Havre de Grace

Capital Specialty Center (Montgomery County)
Establish an ambulatory surgery center with 1 sterile operating room and one non-sterile procedure room to be located at 11400 Rockville Pike, Rockville

Maryland Center for Digestive Health (Anne Arundel County)
Establish an ambulatory surgery center with 3 non-sterile procedure rooms to be located at 818-820 Bestgate Road, Annapolis

Severna Park Plastic Surgery Specialist (Anne Arundel County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 489 Ritchie Highway, Suite 202, Severna Park

Coastal Cosmetic Surgery Center, LLC (Calvert Co.)
Establish an ambulatory surgery center with 1 sterile operating room and 1 non-sterile procedure room to be located at 70 Sherry Lane, Prince Frederick

Jessco, LLC (Worcester County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 10308 Old Ocean City Boulevard, Berlin

Howard County Gastrointestinal Diagnostic Center (Howard County)
Establish an ambulatory surgery center with 3 non-sterile procedure rooms to be located at 10710 Charter Drive, Suite 1300, Columbia

Walbrook Foot and Ankle ASC, LLC (Baltimore City)
Establish an ambulatory surgery center with 1 non-sterile procedure rooms to be located at 2200 Garrison Boulevard, Suite 203, Baltimore

ASC Renew Surgery Center, (Prince George's County)
Establish an ambulatory surgery center with 1 sterile operating room to be located at 4861 Telsa Drive, Suite A, Bowie

Olney Center for Reconstructive Surgery (Montgomery County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 18111 Prince Philip Drive, Suite 204, Olney

Endoscopy Center of North Baltimore, LLC (Baltimore Co.)
Addition of physicians to practice

- **Waiver Beds**

Franklin Woods (Baltimore County)
Request to add 5 CCF waiver beds

Policy and Planning

On December 18, 2008, the Maryland Health Care Commission adopted proposed COMAR 10.24.10, *State Health Plan for Facilities and Services: Acute Care Hospital Services*, as final regulations. Notice of the December 18, 2008 adoption, by the Maryland Health Care Commission, of proposed COMAR 10.24.10, *State Health Plan for Facilities and Services: Acute Care Hospital Services*, as final regulations, was published in the *Maryland Register* on January 16, 2009 and the regulations took effect on January 26, 2009.

Hospital Quality Initiatives

Hospital Performance Evaluation Guide

The Hospital Performance Evaluation Guide has been updated to include calendar year 2007 data for inpatient hospital core quality measures. The staff is working on updating and expanding the hospital profile measures to include information on selected specialized health care services. The staff continues to move forward on implementation of new quality measures on the Hospital Guide. The new measures include expansion of the Surgical Care Improvement Project (SCIP) measures to include all surgical strata (hip, knee, colon, cardiac, CABG, hysterectomy, and vascular surgery). Currently, the Commission reports SCIP measures for hip, knee and colon surgery only. The new measures also include the addition of five new SCIP measures and three new measures associated with Children's Asthma Care. The new quality measures were posted on the Commission's website for comment and have been published as a notice in the *Maryland Register*. The effective date for reporting the new and expanded SCIP measures is January 1, 2009. The effective date for reporting the Children's Asthma Care measures is July 1, 2009.

In addition to the activities associated with the immediate update of the Hospital Guide, staff continues to work on a long term data management strategy which entails the establishment a Quality Measures Data Center (QMDC). The QMDC will provide direct and timely access to detailed patient-level quality and performance measures data. This approach will not only accelerate the timely receipt of data directly from hospitals, but it will enable the Commission to validate the accuracy and completeness of the data as well. Historically, the hospital performance measure data (in summary form) have been obtained from the CMS Quality Improvement Organization (QIO) Warehouse.

On April, 2008, MHCC issued a Request for Proposal (RFP) to Establish and Manage a Quality Measures Data Center ("QMDC"). The QMDC will function as a repository for hospital performance measures and supporting data. A six-member evaluation committee, including four individuals from outside the MHCC, reviewed the proposals submitted in response to the solicitation. The Committee held several meetings to discuss the submissions and to consider all relevant information. The proposal review process has been completed and the Committee recommendation was approved by the Board of Works at its December 17th public meeting. The Iowa Foundation for Medical Care (IFMC) has been awarded the contract effective January 2, 2009. IFMC maintains a local office in Elkridge, Maryland.

Healthcare Associated Infections (HAI) Data

The staff has continued efforts towards implementation of the recommendations of the Technical Advisory Committee on Healthcare-Associated Infections (TAC-HAI). Phase 1 of the TAC-HAI recommendations state that public reporting of data on healthcare-associated infections shall be initiated with the following three measures: Central Line-Associated Bloodstream Infections (CLA-BSIs) in All Intensive Care Units (ICUs), Healthcare Worker (HCW) Influenza Vaccination, and Compliance with Active Surveillance Testing (AST) for MRSA in All ICUs. The TAC-HAI also recommended that a permanent Advisory Committee, comprised of experts in the field of infection control and epidemiology, be established to guide the MHCC's HAI public reporting activities. An HAI Advisory Committee

(HAC) has been established and they provide invaluable guidance in MHCC's HAI data collection and reporting activities.

Since July 1, 2008, Maryland hospitals have been required to use the National Healthcare Safety Network (NHSN) surveillance system to report data to the Commission on Central Line-Associated Blood Stream Infections in any ICU. Hospitals are required by NHSN to report data in the system within 30 days following the end of the month. The staff has worked with the hospitals to facilitate compliance with these new data reporting requirements. All hospitals with ICUs are participating in the system and are now submitting data on CLABSIs in ICUs

A subcommittee of the HAC was formed to recommend options for collecting data on the rate of HCW Influenza Vaccinations in hospitals. The subcommittee reviewed, in detail, possible data elements and definitions, the data collection tool and timeframe. The recommendations of the subcommittee were subsequently approved by the HAC and provided the guidance necessary to issue a preliminary HCW Influenza Vaccination survey to hospitals on November 14th.

A subcommittee of the HAC was also formed to recommend options for collecting data on hospital compliance with Active Surveillance Testing (AST) for MRSA in All ICUs. It is important to note that this is a process measure that evaluates the rate of hospital screening (AST) for MRSA in all ICUs. It is not an outcome measure that evaluates the rate of MRSA colonization or infection in the hospital. The subcommittee discussed, in detail, the current AST for MRSA guidelines and recommendations and considered use of the NHSN surveillance system as the data collection vehicle. The subcommittee recommended use of an on-line hospital survey designed to collect information on the rate of AST for MRSA in ICUs. The staff developed a preliminary survey for hospital review and comment. The survey was disseminated to hospitals on November 14th.

The HAC met on December 1st to review the comments and questions submitted by hospitals and to provide clinical expertise and guidance to staff for development of appropriate responses. The official online surveys will be developed using Survey Monkey software and will be disseminated by the end of February.

Other Activities

In support of MHCC's hospital quality initiatives, the staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. MHCC staff successfully applied for participation in a Workshop on Administrative Data and State Policy sponsored by the Agency for Healthcare Research and Quality (AHRQ). Maryland was one of nine states invited to participate in the two day intensive Workshop held in Rockville, Maryland on December 4th and 5th. Representatives from MHCC, HSCRC, DHMH and the Medical Assistance Program were invited to attend as part of the Maryland team. The Workshop provided an excellent overview of data sources and AHRQ tools available to assist states in addressing policy questions such as public reporting of hospital readmissions as it relates to both quality of care and cost.

On December 9th, the staff presented an overview of MHCC HAI data collection and reporting activities at the annual DHMH Communicable Disease Update Conference in Clarksville, Maryland. The staff continues to collaborate with the HSCRC staff on data issues to support the Quality Based Reimbursement project and broader rate setting issues.

Staff attended the National Quality Forum (NQF) meeting of the Technical Advisory Panel on Hospital Care: Outcomes and Efficiency. The purpose of the meeting was to review proposed hospital performance measures for public reporting and quality improvement. The staff will continue to monitor the NQF review process for new measures to include in the Maryland Hospital Guide.

Specialized Services Policy and Planning

On March 15, 2007, the Commission issued one-year waivers permitting Frederick Memorial Hospital (FMH) and Washington County Hospital (WCH) to establish primary percutaneous coronary intervention (pPCI) services without on-site cardiac surgery services; on May 17, 2007, the Commission granted a one-year pPCI waiver to Upper Chesapeake Medical Center (UCMC). FMH began providing pPCI on March 14, 2008; WCH, on March 15, 2008; and UCMC, on April 4, 2008. The effective date of the one-year waiver was the date on which the hospital initiated pPCI services. In order to retain the waiver, each hospital must attain and maintain compliance with the requirements for pPCI programs found in COMAR 10.24.17, Table A-1. FMH, WCH, and UCMC have filed pPCI waiver renewal applications. The Commission will issue a pPCI waiver for a two-year period, provided that the applicant hospital meets and continues to meet all requirements for pPCI programs without on-site cardiac surgery during the period of the one-year waiver. On February 19, 2009, the Commission will consider the staff recommendation on the applications of Frederick Memorial Hospital (Docket No. 08-10-0036 WR) and Washington County Hospital (Docket No. 08-21-0037 WR).

On May 9, 2008, the Commission published in the *Maryland Register* an updated schedule for receipt of pPCI waiver applications. On January 7, 2009, Northwest Hospital filed an application to initiate a pPCI program. On March 11th, renewal applications from the following hospitals with two-year pPCI waivers are due: Anne Arundel Medical Center, Baltimore Washington Medical Center, and Franklin Square Hospital Center.

CENTER FOR HEALTH INFORMATION TECHNOLOGY

Staff completed its analysis of the *Hospital Health Information Technology Survey* (survey) data that includes the responses from 47 Maryland acute care hospitals. Findings from the survey will be compiled in an information brief that provides an overview of the hospital's current HIT activities. The analysis takes into consideration hospital size, geographical location, and affiliation with other hospitals and health systems. The survey provides a detailed review of HIT adoption, implementation, and utilization that compares the present level of HIT adoption in the state with national activity. This survey is unique in that it assesses each hospital's planning efforts that other national surveys do not take into account. Staff plans to review the preliminary findings with the hospital chief information officers (CIOs), and will release the aggregate findings in April. The Center for Hospital Services is considering including the survey as part of its annual *Maryland Hospital Performance Evaluation Guide*. Over the next six months, staff plans to work with hospital CIOs to develop a rating system that publicly reports on a hospital's level of HIT implementation. Staff intends to conduct a similar survey on freestanding ambulatory surgical centers during the first quarter of 2009.

Efforts are underway to assemble a focus group consisting of participants from the Task Force to Study Electronic Health Records (Task Force). The focus group will meet in March to review the 13 recommendations included in the Task Force's final report that was sent to the Governor and General Assembly in December 2007. The legislative directive was for the Task Force to study electronic health record (EHR) systems; the current and potential expansion of their utilization in Maryland, including the use of electronic transfer, e-prescribing, and computerized provider order entry (CPOE); and the cost of implementing these functions. The Task Force also studied the impact of the current and potential expansion of school health records and issues related to patient safety and privacy. Last month staff reached out to participants to assess their interest in taking part in the focus group. Approximately ten representatives from the Task Force, including the Chair and Vice Chair, will take part in the discussion.

Staff plans to release a briefing document from the focus group meeting during the second quarter of 2009.

Staff awarded a contract to Audacious Inquiry to assist in an initiative aimed at advancing HIT adoption in long term care (LTC). This initiative will focus specifically in the areas of privacy and security and technology. As part of the work, staff plans to develop a product portfolio that includes only those vendors that meet the most stringent Certification Commission for Health Information Technology standards relating to functionality, interoperability, and security. The portfolio will include user references, basic product information, pricing, and privacy and security policies. The goal of the project is to understand the current state of HIT planning and adoption, willingness in LTC to invest and manage the implementation of HIT, and determine what stakeholders need to know and do to support HIT in nursing homes. Staff anticipates releasing a report around the third quarter of 2009.

CareFirst announced its intention to fund the Community Health Integrated Partnership's (CHIP) HIT demonstration project proposal under its *Bridges to Excellence* program. *Bridges to Excellence* provides financial incentives to organizations who take specific steps to promote the delivery of safe, high quality health care. Last summer staff worked closely with CHIP in developing this proposal and provided input to CareFirst during their evaluation process. Staff also provided support to LifeBridge Health Systems in developing their HIT demonstration proposal. CareFirst is in discussion with LifeBridge Health Systems to take part in a medical home demonstration project, where they can expand upon the work effort of their original proposal.

Staff is in the preliminary stages of drafting a report on its evaluation of six different managed service organization (MSO) business models that exist in the market, ranging from hospital affiliation to independent organizations. MSOs have the potential to increase HIT adoption among physician practices as they eliminate the need for an onsite client server by offering a subscription-based, hosted EHR model, also known as Application Service Provider (ASP). An ASP model allows physicians to own the data without managing the security of the information. MSOs implement safeguards that meet industry standards and can be increased at the request of the physician practice. Erickson Health Information Exchange, LLC, provides support for this initiative. Staff intends to release the report during the first quarter of 2009.

Health Information Exchange

The multi-stakeholder groups continued their planning efforts for *A Citizen Centric Health Information Exchange for Maryland.* The groups are in the preliminary stages of drafting their final report, which will address issues related to governance, privacy and security, role-based access, user authentication and trust hierarchies, architecture of the exchange, hardware and software solutions, costs of implementation, alternative sustainable business models, and strategies to assure appropriate consumer engagement, access, and control over information exchange. Staff continues to participate in the planning groups' discussions and to provide feedback on draft sections of the report. A review of the preliminary recommendations from the two planning teams is underway to identify specific requirements to include in the implementation Request for Proposal for a statewide health information exchange. Health Care Information Consultants (HCIC) was selected to provide assistance in reviewing the preliminary recommendations from each of the two planning teams and identify other core components from ten emerging or established HIEs.

Drafting of the *Service Area Health Information Exchange (SAHIE) Resource Guide* (Guide) continued over the last month. An initial draft was completed and scheduled to be circulated for comments by the SAHIE Workgroup (workgroup) in February. The Guide will identify key policy and best practices for communities planning to exchange electronic patient information. In the fall of 2008, a workgroup consisting primarily of hospital chief information officers was convened to address community data sharing challenges regarding a patient's right to control their information; a range of business practices for privacy and security; technical standards; and key financial, organizational, and clinical barriers to

exchanging electronic data. Dynamed Solutions provided assistance in facilitating workgroup meetings and in assessing the data obtained from the meetings. Staff anticipates completing the Guide in the first quarter of 2009.

The Office of the National Coordinator for Health Information Technology (ONC) has subcontracted with Maryland and nine other states to participate in a Health Information Security & Privacy Collaboration's (HISPC) Adoption of Standards Collaborative Workgroup (workgroup). Workgroup participants will develop recommendations for cross HIE treatment of individuals and populations, and the development of an implementation plan that will guide states in the adoption of privacy and security policies for authentication and audit. Policies relating to privacy and security are critical to building provider and consumer trust in electronic patient information. Last month, staff submitted draft recommendations for *Coordinating with the AHIC Successor, Inc.* that will be incorporated into the final report *National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit*. The final report is due to ONC in April 2009.

Staff provided support to the Electronic Health Network Accreditation Commission's (EHNAC) HIE Advisory Panel. The Advisory Panel develops privacy and security policy criteria recommendations for EHNAC to consider including in it's HIE network policy accreditation program. Participants on the Advisory Panel represent various stakeholder groups across the nation. The Advisory Panel met in January to review privacy policies contained in the proposed criteria. The next meeting of the Advisory Panel is scheduled for February. Staff continues to provide support to the Advisory Panel in developing the preliminary policy criteria recommendations for the program. EHNAC anticipates making this accreditation program available to HIEs in the fourth quarter of 2009.

Electronic Health Networks & Electronic Data Interchange
Staff completed the *2008 EDI Progress Report*, which payers use to develop programs aimed at increasing provider use of technology. Copies of the report will be available in early February and online at the Commission's website. COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*, states payers with a premium volume of one million dollars or more are required to submit census data on their administrative health care transactions annually. A web-based application was first used by payers in 2007, which has been evaluated and enhancements to the application are in progress in preparation for the 2008 calendar year reporting cycle in June 2009.

Staff granted candidacy status to one electronic health network (EHN), Quadax; initial certification was awarded to two EHNs Secure EDI and eRx; and recertification was granted to six EHNs, including Misys, Henry Schein Practice Solutions, Navimedix, Claimsnet, Health Fusion, and Electronic Network Services. Certification is awarded by MHCC after a network obtains EHNAC accreditation along with a review of the networks' privacy and security policy assessment. Staff identified eight networks from the 2007 EDI Progress Report that will need to be certified; these networks will be contacted over the next 60 days.

National Networking
Staff participated on the Health Information Management System Society Personal Health Record (PHR) Clinical Outreach Taskforce. Last month the taskforce prioritized the list of FAQs to include in their product release. In addition, staff participated on the Healthcare Information and Management Systems Society (HIMSS) HIE Technology Portfolio Taskforce and on the Healthcare Transformation through Healthcare Information Technology Workgroup.

Staff attended the 5th annual eHealth Initiative Conference (hosted by eHI in Washington, DC) entitled: *Taking the Pulse of Health IT: A Critical Review of Progress Over the Last Five Years and Key Recommendations for 2009 and Beyond*. Key sessions included: improvements in quality and efficiency; engaging consumers and patients; addressing financing issues; and addressing privacy and confidentiality. Staff also attended the *5th NHIN Forum: Nationwide Health Information Network (NHIN) Trial*

Implementations: A Path to Production. The forum presented the work of the NHIN Cooperative, including lessons learned from the Trial Implementations.

Staff participated in several webinars during the month: The State-level HIE Consensus Project through the Foundation of Research and Education of the American Health Information Management Association; HIMSS discussion with key leaders from NeHII, Inc., the statewide HIE initiative taking place in Nebraska; and the AHIC Successor's Board of Directors meeting.